WHY TOM AND JERRY NEED TO TALK

A paradigm shift in thinking is needed to meet the growing demands on eye care.

BY LYNDA McGIVNEY, FAOI

Why do optometrists and ophthalmologists fail to communicate? Is it age-old prejudices? Is it fear of losing control of one's patch? Is it an ignorance of each other's skill sets? Is it because we just do not bother? Are we like Tom and Jerry?

In truth, it is probably a combination of these factors. But the bottom line is that this lack of communication must change—and change fast—because the world is changing faster. If we do not start communicating more efficiently, we will become a parody, like Tom and Jerry. (I will let the reader decide who is the cat and who is his sworn enemy, the mouse, in this analogy to the famous cartoon series.)

IN IRELAND

Consider as an example my home country, Ireland. As in many areas of the world, the demographic profile of Ireland is changing rapidly, and, with this, the health needs of the population are growing at an unprecedented rate. People's expectations of what health care can deliver are also growing.

However, the current system of eye care provision in Ireland is failing to cope with the realities of increased demands and expectations. There are more of us, we are getting older, and we want healthy vision to help us maintain our independent way of living.

The Vision 2020 initiative of the World Health Organization and its international partners seeks to eliminate the main causes of preventable and treatable blindness by 2020. Unfortunately, we are nowhere near that target as things stand. The health and bioscience technologies are there. Why are we so far behind?

The need to meet the demands on the eye care service requires a paradigm shift in the way we look at health care delivery and the roles of the professionals involved. Along with this shift in thinking, improved and more effective communication methods between the professionals involved in this service are called for. We need to park prejudice and begin communicating on all levels.

Traditionally, in Ireland, communication between optometrists working in the community and ophthalmologists has been poor. In some areas, the relationship between ophthalmologists and optometrists is reasonably good, but in more areas it is not. Long-standing bias, the fact that optometrists are not employed in the public health system, and a lack of evidence-based referral pathways in Ireland do nothing to promote and encourage communication between the two professions.

The public system. Currently, within the public system, optometrists are required to refer patients through their general practitioner, resulting in inconvenience, delays, and additional costs to the patient or the national health system. There is a complete absence of communication between the referring optometrist and the receiving ophthalmologist. A referral letter may be provided by the optometrist, but this can go missing or can be misinterpreted in the trail of referral stages.

Once the referral is made, the referring optometrist may have no idea of the diagnosis or treatment received by the patient he or she has referred. Additionally, when the patient is discharged, the onus is on the patient to return to the care of his or her optometrist, and no information on diagnosis or treatment is made available to either party.

The private system. On the other hand, the private system allows direct referral of patients to ophthalmology. There is regular communication between the ophthalmologist

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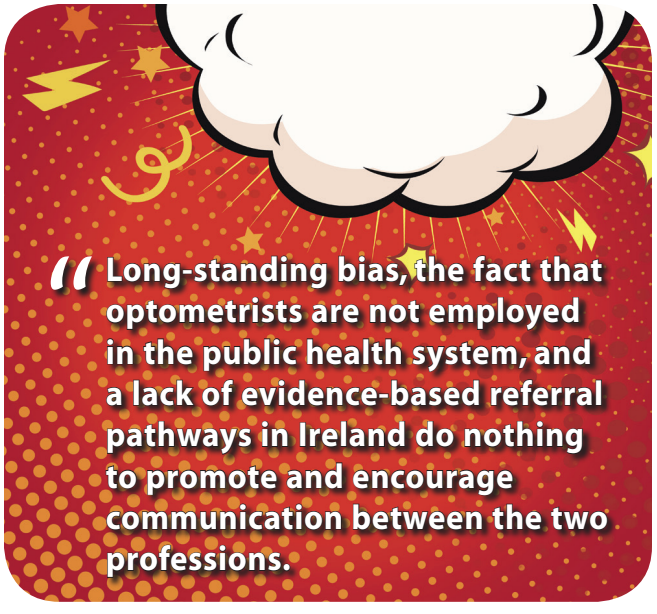

INSIDE THE PRACTICE

LONDON VISION CLINIC

By Sharon Ritchie, BSc (Hons), MCOptom

The key features of any comanagement scheme are communication and education. There must be clear guidance on what is expected of the comanaging eye care provider, not only in terms of patient assessment but also in dealing with routine situations. Optometrists must, of course, work within the recommended guidelines. If we encounter any adverse issues beyond the realm of our clinical capabilities, we must have established, open channels of communication with the treating surgeon in order to ensure patient safety.

GAINING EXPERIENCE AND RESPONSIBILITY

At London Vision Clinic, we have an excellent team of experienced optometrists, most of whom have more than 7 years of laser refractive surgery experience. Because we are all under one roof, we have a close working relationship among team members, with a strong sense of mutual respect. London Vision Clinic prides itself on having extensive standard operating procedures (SOPs) to ensure that each patient is given the best quality of care—from the initial phone call to the clinic visit and through the final postoperative appointment. This also results in consistent medical and psychological support being offered in an equitable format by everyone on the team. We have weekly clinical grand rounds meetings for our optometrists and surgeons to discuss everything from new advances in the field, to the latest on our own research, to new or updated SOPs, to interesting patient presentations.

Every new optometrist at London Vision Clinic completes an intensive training program in which he or she observes all aspects of the patient journey, from the initial screening to informed consent and surgery to subsequent postoperative visits. We spend weeks reading, learning, and understanding the SOPs. We then work under the supervision of our more experienced colleagues for a period of 6 months to get up to speed to run our own clinics for pre- and postoperative patient appointments. With experience comes more responsibility, and working with the surgeons we are able to comanage more advanced therapeutic patients, such as those referred for rehabilitation due to previous suboptimal surgical outcomes.

PATIENT COUNSELING

A large part of my role, in addition to the clinical aspect, is counseling patients before they proceed to refractive surgery. This discussion takes about 45 minutes for a typical patient and allows us to establish what he or she hopes to achieve from surgery and to discover any particular occupational or sporting requirements he or she may have. We focus on aligning the patient's expectations with reality in terms of the typical timeframe for recovery and what occurs during each phase of healing.

The full 2-hour preoperative optometric consultation also includes a comprehensive ophthalmic examination with dilated fundoscopy, along with a discussion of the patient's treatment options. These initial visits are quite intensive, and they set the tone for a strong future relationship with the patient as we establish continuity of care throughout the postoperative visits on a one-on-one basis.

Patients want to feel comfortable within the clinical environment, and they expect professionalism, high standards, and good advice from a consultation. We always aim to deliver on all of these aspects while being open and honest about patient expectations and surgical options. Many patients have unrealistic expectations of refractive surgery, so we spend ample time addressing their concerns, realigning their expectations, and confirming that they accept what is achievable before they meet the surgeon. This, in turn, alleviates any additional stress patients may have at their forthcoming surgeon consent consultation, so that the surgeon can concentrate on making final clinical measurements and gaining any necessary additional information.

In 2012, I underwent refractive surgery for high myopia (OD: -5.50 -0.25 X 133°; OS: -9.00 -1.50 X 160°). This has given me great insight into the procedure from the patient's perspective and has proved to be invaluable in daily practice, as it allows me to empathize with my patients in many areas of their care.

THE FUTURE OF SHARED CARE

Shared care is vital for the future of refractive surgery and indeed many other aspects of medicine across many disciplines. Well-trained comanaging optometrists can ease the pressure on surgeons by carrying out the necessary clinical tests, counseling the patient, and answering his or her questions in advance. The patient then has an established connection with a clinician other than the treating surgeon as a point of contact to help him or her through the postoperative period.

There are already well-established comanagement pathways within optometry for glaucoma and diabetes. Many optometrists would relish the opportunity to expand their knowledge and participate in such schemes. The future of optometry looks to be heading in that direction, at least in this country, as increasing numbers of optometrists in the United Kingdom are furthering their education with clinical masters courses or postgraduate courses such as independent prescribing. This can only be beneficial to the field in the future.

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and the optometrist, including letters of diagnosis, progress reports, and safe discharge back to the care of the community optometrist when appropriate.

This situation results in two different levels of communication in the two systems: (1) In the public sector, effective communication between optometry and ophthalmology does not exist, resulting in a practice that compromises care and outcomes; (2) in the private sector, communication exemplifies best practice principles. It is much easier to enjoy good interprofessional communications in the private arena. In the public arena, personally, I feel like a nuisance. Tom and Jerry, anyone?

LONG WAITING LISTS

One major problem area in the Irish eye care system is the long waiting lists for cataract surgery. With the aging of the population, lists for cataract surgery are growing by the day, resulting in 3-year (and, in some cases, longer) waits for surgery. I was recently contacted by a member of the public who was seeking the services of the National Council for the Blind because he had been waiting so long for cataract surgery that he could no longer see, and there was no prospect of surgery any time soon. To complicate the issue, he and his wife live in a remote area, and, because she does not know how to drive, they rely on him to get around. His

INSIDE THE PRACTICE

WELLINGTON EYE CLINIC

By Ann-Marie Masterson, DipOptom, FAOI, PGDipCRS

When it comes to surgical comanagement, the key to success is for the optometrist to have full knowledge of all surgical procedures available to patients, paying particular attention to inclusion and exclusion criteria for each individual. This allows the optometrist to feel confident that he or she is pointing each patient in the correct surgical direction, carrying out the appropriate tests, and advising the patient of the relevant risks and complications. Patients should ultimately reach the surgeon with a better idea of which treatments they are and are not suitable for. At the Wellington Eye Clinic, we strive to maintain this protocol among all optometrists to best achieve continuity of care and to minimize the surgeon's valuable chair time when possible.

OPEN COMMUNICATION

An everyday open-door policy works well, and the ability to discuss individual patients at that moment and while they are fresh in everyone's minds is ideal. Regular meetings and email updates are essential, as is in-house training involving all members of staff.

Attendance at conferences such as the European Society of Cataract and Refractive Surgeons (ESCRS) annual meeting can be hugely beneficial and help to keep optometrists abreast of up-and-coming procedures before they have even reached the clinic.

THE PATIENT EXPERIENCE

Patients should feel a continuity of care and professionalism across the board. From optometrist to ophthalmologist, we should all be on the same page to instill confidence in the patient to proceed with surgery. To do this, we first need to be confident with our knowledge. Confidence follows from experience and regular, continual training.

With regard to postoperative care, the optometrist's role is to reinforce the happy patient's result. This helps the clinic's outward image and increases word-of-mouth referrals. More important, counseling, reassuring, listening to, and guiding less-satisfied patients toward a good result is key. Turning around an unhappy patient can be hugely satisfying for all involved and can reflect well on the clinic as a whole. I feel it is the experienced optometrist's role to manage these patients as far as is possible.

GROWING INVOLVEMEMNT

I envision optometry having greater involvement in shared care. In trained hands, and with open communication between ophthalmologists and optometrists, there is potential for this approach to work well. In Ireland, there is still some division between ophthalmology and optometry, and, in order for this to improve, better relations must be formed between the two groups before shared care can be an option.

Optometrists need better insight into the treatment pathways ophthalmologists regularly use, and this requires advanced training and experience working alongside ophthalmologists. I hope to see a better blend of care spread among optometrists, general practitioners, and ophthalmologists. When this is achieved, it ultimately should provide better access for patients to the right care at the right time.

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AT A GLANCE

- The demographic profile in many countries is changing rapidly, and the health needs of the population are growing at an unprecedented rate.
- One vital factor underpinning the success of collaborative care is good communication between optometrists and ophthalmologists, encouraged by a healthy mutual respect for each profession.
- To make eye care more efficient and improve outcomes, a primary care system must embrace the complete skill sets of all eye care professionals.

wife explained to me that she calls out the directions to him when they are on the road.

A SUCCESSFUL SCHEME

The potential for change exists. In 2011, Paul Mullaney, FRCOphth, a Consultant Ophthalmologist at Sligo General Hospital in Ireland, decided to address the lack of patient-friendly referral pathways and the strain on resources within the hospital. He changed the way things were done in his cataract clinic. He approached the Association of Optometrists Ireland to explore the viability of referring his postoperative cataract surgery patients directly into the community, where the postoperative ophthalmic examination could be completed by the optometrist, rather than sending the patient back to the hospital when it was not deemed necessary.

Although all elements of the examination were within the legal scope of practice of optometrists, protocols and guidelines had to be set in place so that the optometrists could replicate what was being done in the hospital clinic. This entailed ensuring that all optometrists equipped their practices with Goldmann tonometers and 75.00 D Volk lenses and were competent in the use of the equipment. Additionally, accreditation required training in the use of the Medisoft patient management software system (eMDs), which was in use in the hospital, so that the community optometrists could upload patient examination records to the hospital system. The clinical nurse manager on the hospital surgical team and the information technology manager for the hospital communicated directly with me as the clinical lead for the optometrists.

The scheme quickly demonstrated a high level of success, in terms of both meeting clinical targets and achieving patient satisfaction. Regular audits were carried out to monitor the scheme's progress, and key performance indicators were regularly examined.

The program was an overwhelming success. The scheme was begun in 2011, and, 5 years later, it has been expanded to cover six adjoining counties. More than 60 community optometrists have been trained and accredited to carry out postoperative cataract examinations. At the hospital, waiting lists were reduced significantly, a postoperative cataract outpatient clinic is no longer required, and the hospital resources employed in this clinic have now been redirected elsewhere within the hospital to speed up access to cataract clinics and to shorten waiting lists.

In short, it is a win-win: Optometrists are getting to hone their skill sets, ophthalmology is saving more sight, and patients are getting their vision back sooner.

The scheme has received several awards for innovation, excellence, and use of technology. Above all, the success of the scheme is an excellent example of how communication can function well on two levels: (1) Communication between ophthalmologists and optometrists led to development of the program, and (2) the e-communication platform facilitated communication between the hospital and the community optometrists.

CONCLUSION

There are some excellent examples of shared care and comanagement schemes employing optometrists in the community to work alongside ophthalmologists in hospital eye services (see *Inside the Practice: London Vision Clinic* and *Inside the Practice: Wellington Eye Clinic*). The one vital factor underpinning the success of all these schemes is good communication between optometrists and ophthalmologists, encouraged by a healthy and mutual respect for each profession.

The health care challenges in Ireland are not unique. Globally, the population is increasing and aging. New approaches are required to meet the demands on health care services and the provision of eye care. There is a need for a reallocation of resources and redistribution of clinical interventions, particularly for primary care. To make eye care more efficient and improve outcomes, a primary care system must embrace the complete skill sets of all eye care professionals. However, none of this can be achieved without good interprofessional communication, and good communication cannot be achieved without trust and respect.

Many hands make light work, as the saying goes. Having the right hands in the right places doing the work they are qualified to do—and communicating efficiently and effectively about it—is really something worth talking about. ■

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